87-545

No.

IN THE

Supreme Court of the United States

October Term, 1987

CESAR A. PERALES, as Commissioner of the New York State Department of Social Services,

Petitioner,

– against –

MILDRED KRIEGER,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE NEW YORK STATE COURT OF APPEALS

CORRECTED COPY

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QUESTIONS PRESENTED

1. Whether this Court should grant review of the novel and important federal question posed by the New York Court of Appeals' interpretation of 42 U.S.C. § 1396a(a)(10)(B) to require reimbursement for medical bills paid by recipients prior to applying for medical asistance (medicaid) where the state and federal agencies interpret the federal statutory scheme to bar payments to recipients, and where no other state is known to have made such direct payments?

2. Whether this Court should grant review to resolve the conflict between the decision of the New York Court of Appeals and several federal circuit courts of appeals concerning whether a federal agency's letter interpretation of its own regulations and governing statutes had "no force and effect" unless the interpretation itself was promulgated pursuant to the Administrative Procedure Act, 5 U.S.C. § 553?

LIST OF PARTIES

The parties to the proceedings below were the petitioner, CESAR A. PERALES, the Commissioner of the New York State Department of Social Services, and the respondent, MILDRED KRIEGER. JAMES A. KRAUSKOPF, formerly the Commissioner of the New York City Department of Social Services, was also a party in the state court proceedings as Commissioner of the agency responsible for effecting compliance with determinations and directives issued by the New York State Department of Social Services. Because no issue regarding the City Department's duty to comply is raised herein, and the City Commisioner did not seek state appellate review, he is not named as a party herein.

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IN THE

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No. _____

CESAR A. PERALES, as Commissioner of the New York State Department of Social Services

Petitioner,

v.

MILDRED KRIEGER,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE NEW YORK STATE COURT OF APPEALS

The petitioner Cesar A. Perales, the Commissioner of the New York State Department of Social Services, respectfully prays that a writ of certiorari issue to review the order and judgment of the New York State Court of Appeals entered June 30, 1987.

Opinions Below

The Court of Appeals did not write a separate opinion. The order and judgment of the Court of Appeals has not yet been officially published and is reproduced at la to the Petition. The opinion of the Appellate Division is reported at 121 A.D.2d 488 and is reproduced at 5a-9a. The opinion of the Supreme Court of the State of New York, County of Kings, is reported at 126 Misc. 2d 70 and is reproduced at 14a-19a.

Jurisdiction

The order and judgment of the New York State Court of Appeals was entered June 30, 1987. The jurisdiction of this Court to review the order of the Court of Appeals is invoked under 28 U.S.C. § 1257(3).

Statement of the Case

Respondent Mildred Krieger is a New York State resident who, but for her income and resources, would be entitled to receive Supplemental Security Income. As such, she is eligible for medicaid under New York's state plan as one of the medically needy. 42 U.S.C. § 1396d(a); New York Social Services Law (S.S.L.) § 366(1)(a)(5) (McKinney's ed. 1983).

The medically needy become eligible for medicaid by incurring medical expenses equal to the amount by which their total income exceeds the cash assistance eligibility level. This figure is called the medicaid recipient's "spend-down". Following a finding of the recipient's eligibility, the medicaid program will pay new charges for qualifying medical services in excess of the monthly spend-down to participating providers at scheduled rates. S.S.L. § 367-a(1); 18 N.Y.C.R.R. § 360.17. Prior to 1973, states had the option of covering bills incurred in the preapplication period. United States Department of Health and Human Services (HHS) Medical Assistance Manual, Part 3—10.0-9.00, p.1 (22a). Effective July 1, 1973, the federal statute and implementing regulations require all states to provide for medicaid coverage, on the same basis, for the costs of qualifying medical services which a medically needy person received during the three months preceding his initial application, if the patient would have been eligible in the month in which he incurred the bill. 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914(a) (formerly 45 C.F.R. § 206.10[a][4]); 18 N.Y.C.R.R. § 360.16(c). The

purpose of this retroactive coverage is to protect those eligible for medicaid who do not apply until after they receive care because they did not know medicaid eligibility requirements, or because of the sudden nature of their illness. H. Rep. No. 92-231, 92nd Cong., 2d Sess., 1972 U.S. Code Cong. & Ad. News 4989, 5099.

Medicaid is a vendor-payment program. However, 42 U.S.C. § 1396d(a) provides that a state may, at its option, reimburse individuals for physicians' and dentists' services. The federal regulation implementing section 1396d(a) provides that a state may make direct payments for physicians' and dentists' services only if the state's plan provides for direct payments. 42 C.F.R. § 447.25. The New York State Plan does not provide for direct payments. *See* S.S.L. 367-a; *Kessler* v. *Blum*, 591 F. Supp. 1013 (S.D.N.Y. 1984). The federal statute and implementing regulations do not permit states to make direct payments to recipients other than for physicians' and dentists' services. *See* 42 U.S.C. § 1396d(a); 42 C.F.R. §§ 447.10(c,d); 447.25.

If a participating state does not choose the direct payment option, it must comply with the vendor payment requirement of federal law in order to receive federal financial participation in its medicaid program. 42 U.S.C. §§ 1396, 1396a(32). States whose plans provide only for vendor payment may, however, reimburse patients and their families who paid for services where the agency has delayed in processing, or improperly denied their medicaid applications. 42 C.F.R. § 431.246 (agency must make corrective payments promptly, "retroactive to the date an incorrect action was taken . . . "). New York State's regulations provide for such corrective payments when a recipient has paid for medical care after an erroneous determination of ineligibility or as a result of unjustifiable agency delay in approving an application. 18 N.Y.C.R.R. §§ 352.31(f), 360.17(a)(4). Respondent does

not, however, claim that she is entitled to reimbursement under these regulations.

Prior Proceedings

Respondent commenced a proceeding pursuant to New York Civil Practice Law and Rules (C.P.L.R.) Article 78 in the Supreme Court of the State of New York, Kings County, in which she sought judgment ordering the City and State Departments of Social Services, *inter alia*, to reimburse her, at the medicaid rate, for medical expenses she incurred and paid for in the three months prior to her application for medicaid. All other issues raised by petitioner were settled by stipulation prior to submission for judgment.

The Supreme Court granted the petition. It rejected the agencies' arguments that in New York, medicaid is a vendor-payment program, and that the agencies may not make direct payments to a patient unless the patient paid the bills during a period of unjustifiable delay in the processing of the medicaid application. Special Term held that the agencies had not shown a rational basis for distinguishing between recipients who had paid their bills and those who had not, calling this distinction "arbitrary and capricious." (19a).

The Appellate Division of the Supreme Court, Second Department, affirmed. Applying its interpretation of federal law, the court held that 42 U.S.C. § 1396a(a)(10)(B), which provides that states participating in the medicaid program must assure that the medical assistance "made available" to any eligible person not be less than that made available to any other eligible person, requires that the state depart from its vendor payment program to reimburse patients for bills they paid during the three-month retroactive period provided for in § 1396a(a)(34). It ruled that since the state satisfies unpaid bills incurred during this period, and because it

makes direct payments to patients in cases involving agency error or unjustifiable delay in processing applications, it must make direct payments for paid bills not involving agency error or unjustifiable delay. (7a-8a).

The court ruled that it was not required to defer to an interpretation of applicable federal statutes and regulations contained in a letter from the federal Department of Health and Human Services (HHS). It held that the letter implicates recipients' substantive rights and was ineffective because it had not been promulgated pursuant to the notice and hearing requirements of the Administrative Procedure Act, 5 U.S.C. § 553. (8a-9a).

The New York Court of Appeals affirmed on the opinion of the Appellate Division. (1a-2a).

Reasons for Granting the Writ

POINT I

This court should grant review of the novel and important federal question posed by the New York Court of Appeals' interpretation of 42 U.S.C. § 1396a(a)(10)(B) to require direct payment to recipients, in reimbursement for medical bills paid prior to applying for medicaid, where the state and federal agencies interpret the federal statutory scheme to bar such direct payments.

A writ of certiorari should issue because the New York Court of Appeals' construction of 42 U.S.C. § 1396a(a)(10)(B) presents novel, substantial and important federal issues affecting the national administration of the medicaid program. *Quern* v. *Mandley*, 436 U.S. 725, 734 (1978). Moreover, the state court's construction of the federal statute conflicts directly with the established construction of the statute by HHS, the agency charged with its enforcement. *See Morton* v. *Ruiz*, 415 U.S. 199, 201-2 (1974).

The New York Court of Appeals held that by limiting its obligation to make medical assistance available during the three months prior to application to satisfaction of unpaid bills through provider payments, the state violated 42 U.S.C. § 1396a(a)(10)(B)(i). The court also relied upon a "parity of reasoning" with the limited exception to the vendor payment rule, applicable to cases of agency delay or error, provided for in federal and state regulations. 45 C.F.R. § 431.246; 18 N.Y.C.R.R. § 360.17(a)(4). The decision thus acknowledged that nothing in the plain language of the statutes or regulations requires direct payments. The court's rationale for reading in such a requirement does not survive scrutiny.

Section 1396a(a)(10)(B)(i) of course does not require payment of equal amounts for all recipients but only that medical assistance be "made available" on an equal basis. Petitioner complies by paying participating providers, on the same basis, for the bills of all eligible patients. Petitioner does not reimburse those who pay their own bills, whether incurred before or after acceptance as medicaid eligible, except in the event of agency error or delay, in which case all recipients are reimbursed on the same basis.

Petitioner's practices, which have been invalidated by the court below, are consistent with the definition of "medical assistance" in the federal statute: "payment of part or all of the cost of the following care and services . . . *for* individuals, and with respect to physicians' and dentists' services, . . . *at the option of the State, to individuals* . . . " (emphasis supplied). 42 U.S.C. § 1396d(a).

As the court below recognized, New York has not chosen the direct payment option. This course is indisputably authorized by Section 1396d(a). As the Court held in *Quern* v. *Mandley, supra*, construing a requirement of the Aid to Families with Dependent Children Program

contained in 42 U.S.C. § 602(a)(10) which parallels the equal basis language in 42 U.S.C. § 1396a(a)(10)(B)(i) applicable to medicaid, "[s]ince the statute [establishing the Emergency Assistance (EA) program] clearly offers the States an option whether or not to adopt an EA program, it is in no sense 'eviscerated' when a State chooses to forgo the offer." 436 U.S. at 735.

Petitioner's practices are supported by the federal agency's interpretation of the applicable governing statutes and regulations, an interpretation set forth in the official HHS Medical Assistance Manual and in HHS letters to the state agency. Quoting from the HHS Manual, Part 3-10.9-00 (pp. 5-6), which cites 42 U.S.C. § 1396a(a)(32),(34), and 45 C.F.R. §§ 206.10(a)(4), 249.32 (redesignated as 42 C.F.R. §§ 435.914[a], 447.25, respectively), HHS stated:

> " . . . State payment for retroactive services is required only where persons have not paid for the medical care and services received."

Letter from Arthur J. O'Leary, HHS Regional Medicaid Director, to former New York State Commissioner of Social Services Barbara Blum, dated April 16, 1981 (HHS Letter) (Appendix "G" to the Petition at 26a). *See* n. 2 below. It was clearly reasonable for HHS to read together 42 U.S.C. § 1396a(a)(32), which does not permit direct payments except where a state has taken the direct payment option (or in cases of agency error or delay), and 42 U.S.C. § 1396a(a)(34), which requires payment of bills incurred during the retroactive period, and to interpret them as barring direct payments for retroactive bills in a state that declined the direct payment option for new bills. HHS' interpretation was entitled to substantial deference. *Blum* v. *Bacon*, 457 U.S. 123, 142 (1982).

The lower court's ruling should be reviewed because it is unprecedented and has important consequences. If not reversed, New York will apparently be the only state

required to reimburse patients directly for medical bills which they paid prior to applying for medicaid.[1]

Moreover, the decision has substantial implications beyond New York because it is decided as a matter of construction of federal statutes and because of the Congressional intent that the states provide uniformly for retroactive coverage of medical charges prior to medicaid eligibility. See p. 2 *ante*. Assuming *arguendo* that the court below correctly read the federal statutes, then all states will be required to make direct payments to patients who paid bills during the retroactive period, and HHS must participate in sharing the cost of such payments.

As noted above, the Court of Appeals based its holding on its interpretation of 42 U.S.C. § 1396a(a)(10)(B)(i) and not upon State law. The Appellate Division opinion mentions the state regulation requiring medicaid coverage during the three months prior to application, 18 N.Y.C.R.R. § 360.16(c), but that regulation is merely a restatement of the federal requirement in 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.914(a).

Review should be granted so that New York's administration of the medicaid program will be consistent with that of other states.

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[1] A search of case law, confirmed by a survey of other states' medicaid agencies and discussions with HHS, indicates that no state has taken the direct payment option provided for in 42 U.S.C. § 1396d(a), and that no state reimburses patients directly, except to correct agency error or delay.

POINT II

This court should grant review to resolve the conflict between the decisions of the New York Court of Appeals and of several federal circuit courts of Appeals concerning whether a federal agency's letter interpretation of its own regulations and governing statutes had "no force and effect" unless the interpretation itself was promulgated pursuant to the federal Administrative Procedure Act, 5 U.S.C. § 553.

The New York Court of Appeals' construction of the federal Administrative Procedure Act (APA), 5 U.S.C. § 553, presents novel, substantial and important federal issues affecting the administration of joint federal-state programs. The state court's construction of the APA establishes the novel principle that an agency interpretation of a regulation that touches upon a recipient's substantive rights must itself be promulgated as a regulation.

In holding that the April 16, 1981, HHS letter quoting from the HHS Medical Assistance Manual (HHS Manual) was of "no force and effect," the state court disregarded the federal authorities without expressly finding them in any way inconsistent with, or a departure from, the governing statute and regulations. In so doing, the Court of Appeals implied that any time a federal agency answers a participating state's query and mentions a substantive right, the state agency may not rely on the letter unless it is formally promulgated as a regulation.

The Court interpreted the quotations from the HHS Manual in the HHS letter as establishing a substantive rule without probing further to discover the context of the quotations, or the statutory and regulatory authority upon

which they were based.[2] The usual deference to an agency's interpretation of its own regulations and governing statutes, *see* p. 7 *ante*, required the state court to presume that HHS had a basis in federal law for its letter unless the court specifically reviewed the authorities cited by HHS and found them inapposite.

If the state court had reviewed the sources set forth in the HHS letter, it would have found that neither the letter nor the HHS Manual announced a new rule or made any change affecting established rights to payment for pre-medicaid application bills. What the letter actually does is answer a specific question concerning such bills by interpreting two regulations and a statute, as applied in a state that has not chosen the direct payment option. *See* Point I *ante*. This is exactly the kind of guidance using federal agency expertise on which participating states depend, and to which the courts usually defer.

The lower court's ruling that to be effective, the interpretative ruling set out in the HHS letter and Manual must be promulgated as a regulation pursuant to the APA, 5 U.S.C. § 553, is inconsistent with several deci-

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[2] The HHS Manual itself was not in evidence. The courts below could, however, have taken judicial notice of it as a public document containing the federal agency's internal rules and not subject to dispute. C.P.L.R. § 4511. The HHS Manual's introduction states (21a):

> "The material contained in this Manual is consistent with the Regulations on the subjects and contains no new or different requirements from those in the Regulations."

The portion of the letter that petitioner relies upon itself quotes from the HHS Manual's Answers to Questions 10 and 11 in Part 3-10.9-00, pp. 5-6 (23a-25a). Answer 10 continues a discussion of former 45 C.F.R. §206.10(a)(4) (redesignated as 42 C.F.R. § 435.914[a]) as read in light of the "title XIX requirement that medical assistance payments (except as specified in 45 C.F.R. 249.32 [redesignated as 42 C.F.R. § 447.25)]) must be made by the State agency directly to the provider." (23a-24a).

sions of federal circuit courts of appeals. *E.g.*, *State of New York* v. *Lyng*, ___ F.2d ___, Dkt. No. 86-6261, Aug. Tm. 1987—No. 773, slip op. at 16-18 (2d Cir. Sept. 23, 1987) (where "there was no prior interpretation of the food stamp regulations concerning any program like New York's restaurant allowance, the Secretary [of Agriculture]'s interpretation did not change any 'existing rights or obligations'" and did not have to be published for notice and comment); *St. Mary's Hospital of Troy* v. *Blue Cross & Blue Shield Ass'n*, 788 F.2d 888, 891 (2d Cir. 1986) (HHS "Manual rules have consistently been held to be 'interpretative rules,' and thus exempt from the notice and comment requirements"); *Cubanski* v. *Heckler*, 781 F.2d 1421, 1427-29 (9th Cir. 1986), *cert. granted sub nom. Bowen* v. *Kizer*, 107 S. Ct. 1282 (1987) (since failure to promulgate as regulation a legislative rule set out in HHS Regional Office Manual did not adversely affect a member of the public, it remained valid); *Donovan* v. *Red Star Marine Services, Inc.*, 739 F.2d 774, 781 (2d Cir. 1984), *cert. denied*, 470 U.S. 1003 (1985) (interpretative ruling in Occupational Safety and Health Administration [OSHA] manual did not have to be published for notice and comment); *Donovan* v. *Wollaston Alloys, Inc.*, 695 F.2d 1, 9 (1st Cir. 1982) (not necessary to publish for notice and comment OSHA manual provision that did not adversely affect complainant, i.e., require a change in behavior); *United States* v. *Fitch Oil Co.*, 676 F.2d 673, 678 (Temp. Emer. Ct. App. 1982) (Department of Energy statement did not have to be published for notice and comment where failure to do so did not adversely affect a member of the public); *Smith* v. *Miller*, 665 F.2d 172, 179 n.7 (7th Cir. 1981) (HHS Manual is "intended . . . only as an interpretative rule"); *Conservative Caucus, Inc.* v. *United States*, 650 F.2d 1206, 1211, 228 Ct. Cl. 45 (1981) (interpretative Postal Service manual rules did not have to be published for notice and comment); *Homan & Crimen, Inc.* v. *Harris*, 626 F.2d 1201, 1210 (5th Cir.),

cert. denied, 400 U.S. 975 (1980) (where medicare statute and regulations did not specifically address a subject, HHS letter applying them to a set of facts was interpretative and did not have to be published for notice and comment); *Columbus Community Hospital* v. *Califano*, 614 F.2d 181, 187 (8th Cir. 1980) (HHS Provider Reinbursement Manual for medicare sets forth interpretative rules); *Anderson* v. *Butz*, 550 F.2d 459, 463 (9th Cir. 1977) (interpretative ruling which changes cost to recipients of allocated food stamps had to be published for notice and comment); *Hogg* v. *United States*, 428 F.2d 274, 280 (6th Cir. 1970), *cert. denied*, 401 U.S. 910 (1971) (APA did not require publication for notice and comment of internal delegation of authority by the Attorney General that did not adversely affect a member of the public).

Those cases distinguish between "interpretative" rules and ones which affect existing rights and obligations, generally referred to as "substantive" rules. *Donovan* v. *Red Star Marine Services, Inc.*, *supra*, 739 F.2d at 783. The APA provisions apply with respect to "substantive" rules only. *Id.* Since the HHS letter and Manual here did not change any existing rights or obligations, merely applying the law and regulations to a particular set of facts, they did not have to be published for notice and comment. *Homan & Crimen, Inc.* v. *Harris*, *supra*, 626 F.2d at 1210.

In declining to give effect to the HHS letter and Manual, the Court of Appeals erroneously relied on *Morton* v. *Ruiz*, *supra*, 415 U.S. at 231-238. In *Morton*, this Court denied deference to the Manual of the Bureau of Indian Affairs (BIA Manual) because it established a substantive rule excluding Indians not living on reservations from receiving general assistance benefits and because the rule was inconsistent with the Congressional purpose of the statute in question. There was thus no statutory or regulatory source for the substantive rule announced in

the BIA Manual. In the present case, however, the HHS Manual is consistent with the statute and regulations and adds no substantive rule affecting eligibility for benefits.

Review should be granted because the order and judgment below conflicts with existing precedent. Moreover, the decision has implications beyond New York because it is an interpretation of a federal statute, and beyond the administration of the medicaid program because it is equally applicable to the myriad of other programs in which the federal government provides funds to the states to use in implementing federal initiatives in accordance with federal statutory and regulatory requirements.

Conclusion

The petition for a writ of certiorari should be granted.

Dated: New York, New York
September 28, 1987

Respectfully submitted,

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APPENDIX

APPENDIX A
ORDER AND JUDGMENT OF THE COURT OF APPEALS

Remittitur

Court of Appeals
State of New York

The Hon. Sol Wachtler, Chief Judge, Presiding

2 No. 181

In the Matter of MILDRED KRIEGER,

Respondent,

v.

JAMES A. KRAUSKOPF,
COMMISSIONER OF THE
NEW YORK CITY
DEPARTMENT OF SOCIAL SERVICES,

Respondent,

CESAR A. PERALES,
COMMISSIONER OF THE
NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES,

Appellant.

Order

The appellant in the above entitled appeal appeared by Hon. Robert Abrams, Attorney General of the State of New York; *the respondent(s) appeared by* Joan Mangones, Esq., The Legal Aid Society and John E. Kirklin, Esq., The Legal Aid Society.

The Court, after due deliberation, orders and adjudges that the order is affirmed, with costs, for the reasons

stated in the memorandum at the Appellate Division (121 AD2d 448). Chief Judge Wachtler and Judges Simons, Kaye, Alexander, Titone, Hancock and Bellacosa concur.

The Court further orders that the papers required to be filed and this record of the proceedings in this Court be remitted to the Supreme Court, Kings County, *there to be proceeded upon according to law.*

I certify that the preceding contains a correct record of the proceedings in this appeal in the Court of Appeals and that the papers required to be filed are attached.

/s/
.....
Donald M. Sheraw, Clerk of the Court

Court of Appeals, Clerk's Office, Albany, June 30, 1987.

APPENDIX B
ORDER OF THE APPELLATE DIVISION, SECOND DEPARTMENT

At a Term of the Appellate Division of the Supreme Court of the State of New York, Second Judicial Department, held in Kings County on June 9, 1986

HON. MILTON MOLLEN, Presiding Justice,
HON. LEON D. LAZER,
HON. GUY J. MANGANO,
HON. WILLIAM C. THOMPSON. } *Associate Justices*

In the Matter of MILDRED KRIEGER,

Petitioner-respondent,

v.

JAMES A. KRAUSKOPF,
COMMISSIONER OF THE
NEW YORK CITY
DEPARTMENT OF SOCIAL SERVICES,

Respondent,

CESAR A. PERALES,
COMMISSIONER OF THE
NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES,

Appellant.

} Order

In the above entitled proceeding pursuant to CPLR article 78, inter alia, to review a determination of the New York State Commissioner of Social Services, dated September 13, 1983, and made after a statutory fair

hearing, which failed to direct the local agency to reimburse the petitioner for medical expenses incurred and paid by the petitioner, a Medicaid enrollee, during the three-month period immediately preceding the filing of her accepted Medicaid application, the above named Cesar A. Perales, Commissioner of the New York State Department of Social Services, a respondent in the court below, having appealed to this court from a judgment of the Supreme Court, Kings County, dated October 12, 1984, which annulled the determination denying reimbursement and directed the New York City Commissioner of Social Services to reimburse the petitioner for those expenses; and the said appeal having been argued by Joseph F. Wagner, Esq., of counsel for appellant and argued by Lester Helfman, Esq., of counsel for petitioner-respondent (one brief filed), due deliberation having been had thereon; and upon this court's opinion and decision slip heretofore filed and made a part hereof, it is

ORDERED that the judgment appealed from is hereby unanimously affirmed, with costs.

/s/ Martin H. Brownstein

Acting Clerk of the Appellate Division

APPENDIX C—
OPINION AND DECISION SLIP OF THE APPELLATE DIVISION, SECOND DEPARTMENT

In the Matter of MILDRED KRIEGER, Respondent, v JAMES A. KRAUSKOPF, as Commissioner of the New York City Department of Social Services, Respondent, and CESAR A. PERALES, as Commissioner of the New York State Department of Social Services, Appellant.—In a proceeding pursuant to CPLR article 78, *inter alia*, to review a determination of the New York State Commissioner of Social Services, dated September 13, 1983, and made after a statutory fair hearing, which failed to direct the local agency to reimburse the petitioner for medical expenses incurred and paid by the petitioner, a Medicaid enrollee, during the three-month period immediately preceding the filing of her accepted Medicaid application, the New York State Commissioner of Social Services (hereinafter the State Commissioner) appeals from a judgment of the Supreme Court, Kings County (Bellard, J.), dated October 12, 1984, which annulled the determination denying reimbursement and directed the New York City Commissioner of Social Services to reimburse the petitioner for those expenses.

Judgment affirmed, with costs.

After a statutory fair hearing was conducted on the issue of the petitioner's eligibility to receive Medicaid benefits, the State Commissioner determined that the petitioner could receive Medicaid reimbursement in any month in which her medical expenses exceeded her surplus income of $19.80. The petitioner commenced this proceeding, challenging, *inter alia*, the Commissioner's determination as to the period for which she was entitled to Medicaid reimbursement. Thereafter, all but one issue raised in the petition with respect to the petitioner's Medicaid coverage were settled by a stipulation among

the petitioner and the city and State Commissioners of Social Services. The remaining issue is whether the petitioner is entitled to reimbursement for medical services covered by Medicaid received and paid for by the petitioner during the three-month period preceding the submission of her Medicaid application. Special Term held that the petitioner was entitled to reimbursement and, in that respect, annulled the State Commissioner's determination. We agree, and, accordingly, affirm the judgment entered upon Special Term's decision.

The pertinent Federal statutes and Federal and State regulations provide for reimbursement to Medicaid enrollees for those covered medical expenses incurred and paid for during the three-month preapplication period (*see*, 42 USC § 1396a [a] [34]; 42 CFR 435.914; 18 NYCRR 360.16 [c]). The State Commissioner contends on appeal that the petitioner may not be directly reimbursed for the payments she made during the three-month preapplication period, and that payments may only be made to providers of the services rendered. We reject this contention.

42 USC § 1396a (a) (10) (B) provides that medical assistance provided to one individual under the Medicaid program shall not be less in amount, duration or scope than the assistance provided to any other individual enrolled in the program. This provision specifically applies to the petitioner (*see*, 42 USC § 1396a [a] [10] [A] [ii]; §1396d [a] [iii]). Federal statute and regulation further provide that a State may make payments under the Medicaid program to service providers or to individuals if the State plan so provides (*see*, 42 USC § 1396a [a] [32]; 42 CFR 447.10 [d]; 447.25). New York's Social Services Law § 367-a (1) permits payment only to service

providers "except as otherwise permitted or required by applicable federal and state provisions, including the regulations of the department [of Social Services]". The New York regulations in turn permit payment to various providers, and to individuals when there has been an error made by the Department of Social Services prompting an individual's Medicaid application to be rejected and that individual is later enrolled in the Medicaid program (*see*, 18 NYCRR 360.17 [a] [4]).

We have previously stated that a Medicaid applicant should not be denied reimbursement simply because Social Services Law § 367-a is a vendor statute (*see*, *Matter of Lustig* v *Blum*, 80 AD2d 558, 559). In addition, we have required the Department of Social Services to reimburse individuals for Medicaid-covered services which they received and paid for directly when the delay in granting the individuals' Medicaid applications was excessive (*see*, *Matter of Lustig* v *Blum*, *supra*; *Matter of Cole* v *Wyman*, 40 AD2d 1033; *see also*, *Matter of Lawrence* v *Lavine*, 50 AD2d 734).

By parity of reasoning, we perceive of no legally valid basis for denying the petitioner direct reimbursement in the instant matter. Support for this conclusion may be found in the requirements of 42 USC § 1396a (a) (10) (B) and 18 NYCRR 360.16 (c) that equal benefits be made available to applicants and that such benefits be made available to applicants in the three-month preapplication period. To hold otherwise would lead to the creation of two classes of Medicaid recipients, one of which would receive fewer benefits solely because the members of the class paid their medical bills promptly, and the other which would receive greater benefits by way of reimbursement to the providers of medical serv-

ices because the members of the class did not pay their medical bills promptly.

The State Commissioner relies upon a letter from the Department of Health and Human Services, dated April 16, 1981, which states that individuals who have received and paid for Medicaid-covered medical services during the three-month preapplication period may not be reimbursed directly. Such reliance is misplaced. Promulgation of a substantive rule must be accomplished in a manner consistent with the provisions of the Administrative Procedure Act (5 USC § 553). A substantive rule had been defined as one affecting individual rights and obligations and having the force and effect of law (*see, Chrysler Corp.* v *Brown*, 441 US 281, 301-302). The April 16, 1981 letter and the Medical Assistance Manual upon which it is based state a substantive rule as the provision affects individual rights and obligations of those who have paid for Medicaid-covered services during the three-month preapplication period. Moreover, if given effect, the rule would bind the State with respect to repayment of those services. Yet the record fails to demonstrate that the procedures required by the Administrative Procedure Act for the promulgation of rules have been followed (*see*, 5 USC § 553; *see also, Chrysler Corp.* v *Brown, supra*, p 303). Therefore, the alleged rule contained in the letter is of no force and effect (*see, Buschmann* v *Schweiker*, 676 F2d 352, 355-356; *Carter* v *Blum*, 493 F Supp 368, 372).

Nor was the alleged rule published in the Federal Register as required by 5 USC § 552 (a) (1) (D). The failure to do so precludes the unpublished rule from being enforced unless the person against whom enforcement is sought to be effected has had actual and timely

notice of the terms of the unpublished rule (*see*, 5 USC §552 [a] [1]; *Morton* v *Ruiz*, 415 US 199, 233). The record at bar does not show that petitioner had actual and timely notice of the provision contained in the letter. Thus, she may not be adversely affected thereby.

Finally, we hold that the petitioner's claim presents a justiciable issue for this court's determination. Whether administrative action violates applicable statutes and regulations is a question within the traditional competence of the courts to decide (*see, Matter of Dental Socy.* v *Carey*, 61 NY2d 330, 335). Mollen, P.J., Lazer, Mangano and Thompson, JJ., concur.

APPENDIX D
ORDER AND JUDGMENT OF THE SUPREME COURT, KINGS COUNTY

At a Special Term, Part I of the Supreme Court of the State of New York, held in and for the County of Kings at the Courthouse located at 360 Adams Street in the Borough of Brooklyn, City and State of New York on the 12th day of October 1984.

PRESENT:

HON. WILLIAM C. BELLARD JUSTICE

In the Matter of the Application of MILDRED KRIEGER, *Petitioner,* For a Judgment Pursuant to Article 78 of the Civil Practice Law and Rules, *–against–* JAMES A. KRAUSKOPF, Commissioner of the New York City Department of Social Services; and CESAR A. PERALES, Commissioner of the New York State Department of Social Services, *Respondents.*	Index No. 24194/83 *Judgment*

Order and Judgment of the Supreme Court, Kings County

The issues in the above entitled proceeding brought pursuant to Article 78 of the Civil Practice Law and Rules for a judgment *inter alia* annulling so much of the respondent's decision which failed to order respondents to reimburse petitioner under the Medical Assistance Program ("Medicaid") for out-of-pocket medical expenses which exceeded her $19.80 monthly surplus income amount for each month from February 1983 through May 1983, (all other issues raised by the First Amended Verified Petition dated January 12, 1984 having been settled by Stipulation dated April 25, 1984), having come on to be heard before the Hon. William C. Bellard on the 23rd day of May 1984.

NOW, upon reading the Order to Show Cause signed by the Hon. Thomas J. Mirabile on July 6, 1984 and the Petition of MILDRED KRIEGER verified on July 5, 1984 and the exhibits annexed thereto, and the Notice of Motion of respondent PERALES dated July 11, 1983 and Affirmation of SHIRLEY BEDOR ORTEGO in support thereof dated July 11, 1983 and the exhibits annexed thereto, and the answer of respondent KRAUSKOPF verified on July 12, 1983, and the Stipulation of counsel for the respective parties dated July 22, 1983, and the Copy Order of the Hon. Frank Vaccaro dated October 4, 1983, and the First Amended Petition of MILDRED KRIEGER, verified on January 12, 1984, and the Stipulation signed by counsel for the respective parties dated January 17, 1984, and the Answer of respondent KRAUSKOPF verified on April 25, 1984 and the Answer of respondent PERALES verified on April 25, 1984 and the exhibits annexed thereto, and the Memorandum of Law in Support of Respondent Perales' Answer dated April 25, 1984, and the Stipulation of Partial Settlement dated April 25, 1984, and the Petitioner's Memorandum of Law in Support of

the First Amended Petition dated May 23, 1984, and respondent Perales' Reply Memorandum dated May 31, 1984, and having heard LESTER HELFMAN, of counsel, to JEFFREY G. ABRANDT, attorney for the petitioner, in support of the Petition, and SHIRLEY BEDOR ORTEGO, of counsel to ROBERT ABRAMS, Attorney General of the State of New York, attorney for respondent Perales and RICKI ANN FELDMAN, of counsel to JOSEPH M. ARMSTRONG, attorney for respondent KRAUSKOPF, and the Court having after due deliberation, on the 4th day of September 1984 made and filed a decision in writing granting the petition and annulling so much of the decision of the respondent State Commissioner which denied reimbursement to the petitioner, at the medical assistance rate, for medical bills she incurred and paid for in the three months prior to applying for medical assistance,

NOW, on motion of LESTER HELFMAN, ESQ., of counsel to the attorney for petitioner, it is hereby

ORDERED AND ADJUDGED that so much of the Decision After Fair Hearing dated September 13, 1984 which failed to direct respondents to reimburse petitioner for paid medical expenses incurred in or after the third month before the month in which the petitioner's Medicaid application was made, specifically from February 1, 1983 through May 11, 1983, is annulled, and it is further

ORDERED AND ADJUDGED that within thirty days of the entry of this Order and Judgment, respondent KRAUSKOPF'S successor in office, reimburse petitioner, at the Medical Assistance reimbursement rate for medi-

cal bills she incurred and paid for between February 1, 1983 and May 11, 1983.

Enter

/s/
.....
J.S.C.

/s/
.....
Clerk

APPENDIX E
DECISION OF THE SUPREME COURT, KINGS COUNTY

In the Matter of MILDRED KRIEGER, Petitioner, v JAMES A. KRAUSKOPF, as Commissioner of the New York City Department of Social Services, et al., Respondents.

Supreme Court, Special Term, Kings County, September 4, 1984

APPEARANCES OF COUNSEL

Lester Helfman for petitioner. *Frederick A.O. Schwarz, Jr., Corporation Counsel* (*Ricki Ann Feldman* of counsel), for James A. Krauskopf, respondent. *Robert Abrams, Attorney-General* (*Shirley Bedor Ortego* of counsel), for Cesar A. Perales, respondent.

OPINION OF THE COURT

WILLIAM T. BELLARD, J.

In this CPLR article 78 proceeding, petitioner seeks reimbursement from respondents for out-of-pocket payments made by her for medical care and treatment received within the three-month period immediately preceding the date she applied for Medicaid.

Respondent defends the denial of reimbursement upon the ground that pursuant to New York State's Social Services Law payment may only be made to the supplier or provider of medical care or services, thus they have no obligation to petitioner. Petitioner contends that once having determined her to be eligible for medical benefits, the denial of reimbursement was arbitrary, capricious and an abuse of discretion.

Petitioner is 78 years old and suffers from angina pectoris, hypertension, a duodenal ulcer, basal cell carcinoma and glaucoma. Her rent, food, utilities and other necessities must be paid for from her only source of income, Social Security benefits.

Decision of the Supreme Court, Kings County

An application for Medicaid benefits was submitted by petitioner on May 12, 1983, to the New York City Department of Social Services (N.Y.C.D.S.S.). When that agency failed to act on petitioner's application within the 30-day period mandated by law, petitioner commenced this proceeding to compel respondent N.Y.C.D.S.S. to provide her with Medicaid. On July 8, 1983, petitioner was notified that although she was not eligible for Medicaid because she received $15 a month more income than was allowable at the time, she nevertheless could receive benefits in any month where her medical expenses exceeded her surplus income. Petitioner requested and received a fair hearing which was held on August 1, 1983 resulting in a decision rendered on September 13, 1983. The decision found, *inter alia*, that the city agency failed to timely take action on petitioner's application. After finding that petitioner had surplus income of $19.80 a month, the decision stated that the city agency had to provide petitioner with an opportunity to verify her increased health insurance costs effective July 1, 1983 and recompute her financial eligibility based on these costs and the recently amended income eligibility requirements. The decision made no provision for reimbursement of petitioner's out-of-pocket medical expenses incurred after respondent failed to provide her with Medicaid.

On October 7, 1983 respondent city agency finally found petitioner to be eligible for Medicaid from July 1, 1983 to May 31, 1984. However, there remained several unsettled issues involving, *inter alia*, reimbursement of medical bills. On April 25, 1984, by stipulation, the parties agreed to resolve all issues between them with one exception, to wit, petitioner's claim that respondents are required to reimburse her for paid medical expenses in-

curred by petitioner between February 1, 1983 and May 11, 1983, inclusive.

Thus, the issue presently before the court, in petitioner's view is whether respondents, despite a determination that petitioner is eligible for Medicaid coverage, can refuse to reimburse her medical expenses simply because those bills have already been paid when such reimbursement would be made if the bills were still outstanding.

Not unexpectedly, respondents frame the issue simply as to whether the State Commissioner's failure to direct the agency to reimburse petitioner, at the medical assistance rate, for medical bills she incurred and paid for prior to applying for medical assistance is arbitrary and capricious.

A State, in order to qualify for contribution of funds from the Federal Government for a medical assistance program, must conform to the guidelines promulgated by Congress (US Code, tit 42, § 1351 *et seq.*). New York State participates in the Medicaid program and receives Federal funding under its State plan (Social Services Law, § 363 *et seq.*). Under section 1396a (subd [a], par [32]) of title 42 of the United States Code, "[A] State plan for medical assistance must provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service". Moreover, section 1396a (subd [a], par [34]) provides that, "in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application * * * for such assistance if

such individual was * * * eligible for such assistance at the time such care and services were furnished". It is also clear that under the appropriate Federal regulations reimbursement to the recipients of medical services who have made direct payment to the provider is permitted (42 CFR 447.10 [d] [2]; 447.25). But, subdivision 1 of section 367-a of the New York Social Services Law states that "any payment with respect to any medical assistance shall be made to the person, institution, state department or agency or municipality supplying such medical assistance * * * except as otherwise permitted to required by applicable federal or state provisions, including the regulations of the department". The State regulations mandate that, "[a]ny payment with respect to any item or medical care under medical assistance shall be made to the person or institution supplying the care" (18 NYCRR 360.17).

Respondent State Commissioner argues that because New York Social Services Law and regulations require payment to be made to the person who provides the medical service or care, no reimbursement to petitioner is permitted. The court disagrees with respondents and concludes there is no merit to this contention since it has been rejected by the courts time and time again (*Matter of Cole* v *Blum*, 86 AD2d 749; *Matter of Lustig* v *Blum*, 80 AD2d 558; *Matter of Schwartz* v *Toia*, 68 AD2d 890; *Matter of Lawrence* v *Lavine*, 50 AD2d 734; *Matter of Cole* v *Wyman*, 40 AD2d 1033). Each of the cited cases involved the issue of a petitioner's request for reimbursement of payments for medical care and services. The courts uniformly held that an otherwise eligible recipient or his family may not be reimbursed funds paid directly to the vendor of medical care unless the expenses were incurred during an unjustifiable delay in the agency's ap-

proval of the medical application. However, none of these cases nor the ones cited by the parties in this proceeding in their respective briefs are relevant to the central question posed herein because they all involve situations where the recipient made payment *after* submitting an application for Medicaid. In the present action payment occurred within the three-month period *preceding* the date of application. Accordingly, we are apparently faced with a case of first impression.

18 NYCRR 360.16 (c) states that, "[A]n initial authorization shall be issued and made effective for inpatient and outpatient care and services provided a person during the three-month period preceding the month of application for medical assistance, if the applicant was eligible in the month in which such care or services were provided; but in no event shall an authorization be issued with respect to care or services provided prior thereto." The aforesaid regulation was discussed in the case of *Matter of Kohl* v *Blum* (92 AD2d 498), a case that was concerned with two article 78 proceedings involving Medicaid reimbursement for payment of personal health care services. Both petitioners had insisted on their entitlement to repayment of funds expended by them for medical services within the three-month period prior to the date of application for Medicaid benefits. The court, however, declined to render judgment on the issue raised because both proceedings involved petitioners seeking reimbursement for payments made to personal home care attendants rather than physicians or dentists. Most importantly, in dicta, the court said (*supra*), 18 NYCRR "360.16 (c) may reasonably be construed by the agency to require reimbursement to the recipient for medical assistance provided during the three-month period preceding the month of application only where the services were

provided by a physician or dentist." The decision was unanimous.

Retroactive reimbursement to a medical assistance recipient should be determined in light of all circumstances of a particular case and should not provide a windfall (*Moran* v *Lascaris*, 61 AD2d 405). It seems to this court, before whom the above-mentioned issue has been squarely placed, that under the facts and circumstances of this case and in the interests of justice, petitioner herein is entitled to reimbursement for any moneys she expended for medical care and services expenses which exceeded her monthly surplus in the three months preceding her date of application for Medicaid benefits. Respondents have failed to rationally explain why a recipient who has been granted Medicaid benefits and has incurred unpaid medical bills during the three months preceding the application month should be granted reimbursement while a similarly situated recipient who has paid his medical bills is denied reimbursement. Thus, the State Commissioner's decision was arbitrary and capricious.

The petition is granted. The decision of respondent State Commissioner denying reimbursement to petitioner is annulled. Respondent city agency (N.Y.C.D.S.S.) is directed to reimburse petitioner, at the applicable medical assistance rate, for medical bills she incurred and paid for in the three months prior to applying for medical assistance.

APPENDIX F
HHS MANUAL

U.S. Department of Health, Education, and Welfare [Department of Health and Human Services], Social and Rehabilitation Service, Medical Services Administration, Medical Assistance Manual

[Page MSA-PRG-1 p.1]

	MSA-PRG-1
Introduction	5/31/71

I. *Purpose*

The purpose of this Manual is to assist States in implementing SRS Program Regulations pertaining to the administration of medical assistance. It is an official medium by which the Medical Services Administration issues guides and procedures to States for the operation of certain aspects of the medical assistance program under the Social Security Act, as amended, and related legislation.

II. *Content*

This Manual clarifies, explains, and expands upon the meaning of the Regulations and the provisions upon which they are based. It may include essential background information; clarification as to mandatory, prohibited, or permissive provisions; scope of flexibility; interpretation in relation to problems that arise in working with the regulations; and other related material such as the Federal Percentages. Interpretations and instructions relating to money payments under Titles I, IV-A, X, XIV, and XVI not pertaining to medical assistance are issued separately but in instances in which all six titles have

common policy, the interpretations and instructions are included.

III. *Relationship to Regulations*

The material contained in this Manual is consistent with the Regulations on the subjects and contains no new or different requirements from those in the Regulations. Regulations are published in the *Federal Register*, appear in the Code of Federal Regulations, and are issued to States as SRS Program Regulations. The Regulations present the specific requirements, developed from the Federal legislation, that States must meet in the State plan and in claiming Federal financial participation.

* * *

[Page MSA-PRG-1 p.2]

/s/ Howard Newman

Commissioner

Medical Services Administration

HHS Manual

[Part 3-10.9-00 p.1]

Part 3. Application, Determination of Eligibility, and Furnishing Assistance

3-10.9-00 Coverage Prior to Application for Medical Assistance—Answers to Questions

Legal Background and Authority

A. Title XIX of the Social Security Act as amended, Section 1902(a)(34)

B. 45 CFR 206.10(a)(6) (SRS Program Regulation 10-11 (C-14), December 3, 1973).

C. U.S. Senate Report 92-1230, 92nd Congress, 2nd Session, September 26, 1972, p. 209.

Introductory Statement

Questions have been raised regarding the proper interpretation of 45 CFR 206.10(a)(6) which provides for coverage prior to application for medical assistance. Prior to enactment of P.L. 92-603, a State, at its own option, could provide medical services to an otherwise qualified recipient up to three months prior to application for Medicaid. Previously, thirteen States provided three months retroactive coverage to persons who were eligible for Medicaid but who did not apply for assistance until after they received care either because of not knowing about Medicaid eligibility requirements, or because the nature of their illness prevented the filing of an application. Effective July 1, 1973, section 1902 (a)(34) requires all States to provide coverage for care and services in or after

the third month prior to application to those individuals who were otherwise eligible when the services were received.

Answers to Questions

* * *

[Part 3-10.9-00 p.5]

Question 9:

How will retroactive coverage be applied in those cases where a person has resided in a State for less than three months before applying for Medicaid benefits?

Answer:

45 CFR 206.10(a)(6) requires all States to provide three months retroactive coverage for Medicaid if the individual was eligible at the time services were rendered in the retroactive period. In States which limit Medicaid coverage to persons who are residents of the State, the retroactive coverage period begins with the date the applicant established residency in the State.

Services received prior to the time an individual establishes residency in the new State are the responsibility of the previous State provided that he was, or on application would have been, eligible in that State and the services were covered under its State plan.

Question 10:

If the recipient had paid for care and services during the three months prior period, would the State have responsibility for repayment

since payment in title XIX provides payments only to vendors?

Answer:

This regulation does not override the title XIX requirement that medical assistance payments (except as specified in 45 CFR 249.32) must be made by the State agency directly to the provider. The regulation is applicable to all medical care and services provided in the three months prior to month of application *except* for physicians' and dentists' services furnished to medically needy persons *if* the State plan makes specific provisions for direct payment to the recipient for such services (45 CFR 249.32 authorizes a State to make direct payments to individuals who are not receiving cash assistance, for physicians' or dentists' services). With this exception, however, State payment for retroactive services

[Part 3-10.9-00 p.6]

is required only where persons have not paid for the medical care and services received in the three months prior to the month of application. If the vendor is willing to refund the payment to the recipient and bill the State for the service, the State would then be expected to make payment provided the service was necessary and the person was eligible for coverage when the service was rendered.

Question 11:

If the recipient has made partial payment, but not payment in full (i.e., has not yet made

payments up to the reasonable charges recognized by a State under 45 CFR 250.30), does the State have the responsibility for outstanding unpaid amounts of the bill to providers?

Answer:

Yes. The State is responsible for unpaid medical care (within the limits of charges it has established pursuant to 45 CFR 250.30) which was provided during the three months prior to month of application provided the person was eligible at the time such services were furnished.

APPENDIX G—HHS LETTER

DEPARTMENT OF HEALTH & HUMAN SERVICES
Healthcare Financing Administration

Refer to: 0:10

Region 11
Federal Building
26 Federal Plaza
New York, NY 10278

APR 16 1981

Mrs. Barbara Blum, Commissioner
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

This is in response to Russell Schwartz's recent letter concerning reimbursement to a recipient for medical services received and paid for prior to application for Medicaid.

Mr. Schwartz states that the current procedures is for the provider to refund the payment to the recipient and then bill the State for the services rendered. He asks if FFP would be available if the procedure was modified to permit a provider, (who was paid for services rendered, by a recipient prior to application for Medicaid) to bill Medicaid and upon payment, reimburse the recipient.

FFP would not be available. Section 3-10.9-0 of the Medical Assistance Manual states: " . . . State payment for retroactive services is required only where persons have not paid for the medical care and services received. If the vendor is willing to refund the payment to the recipient and bill the State for the service, the State would then be expected to make payment, provided the service was necessary and the person was eligible for coverage when the service was rendered." Additionally, Section

HHS Letter

3-10.9-0 states: "The State is responsible for unpaid medical care within the limit of charges it has established . . . "

We hope this satisfies your question.

Sincerely,

/s/

Arthur J. O'Leary
Regional Medicaid Director

APPENDIX H
STATUTES AND REGULATIONS INVOLVED

I. FEDERAL STATUTES

5 U.S.C. § 553. Rule making

(a) This section applied, according to the provisions thereof, except to the extent that there is involved—

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued)

that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except—

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

* * *

(10)(B) that the medical assistance made available to any individual described in subparagraph (A)—

> (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, ...

* * *

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

> (A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; . . .

* * *

(34) provide that in the case of any individual who has been determined to be eligible for medical

assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

* * *

42 U.S.C. § 1396d. Definitions

For purposes of this subchapter—

(a) Medical Assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a (a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or Part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter....

* * *

II. Federal Regulations

42 C.F.R. §431.246 Corrective action.

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—

(a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

42 C.F.R. §435.914 Effective date.

(a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—

(1) Received Medicaid services, at any time during that period, of a type covered under the plan; and

(2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

(b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.

(c) The State plan must specify the date on which eligibility will be made effective.

42 C.F.R. §447.10 Prohibition against reassignment of provider claims.

* * *

(c) *State plan requirements.* A State plan must provide that the requirements of paragraphs (d) through (h) of this section are met.

(d) *Who may receive payment.* Payment may be made only—

(1) To the provider; or

(2) To the recipient if he is a non-cash recipient eligible to receive the payment under § 447.25....

* * *

42 C.F.R. §447.25 Direct payments to certain recipients for physicians' or dentists' services.

(a) *Basis and purpose.* This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain recipients for physicians' or dentists' services.

(b) *State plan requirements.* Except for groups specified in paragraph (c) of this section, a State may make direct payments to recipients for physicians' or dentists' services. If it does so, the State plan must—

(1) Provide for direct payments; and

(2) Specify the conditions under which payments are made.

* * *

(d) *Federal requirements.* (1) Direct payments to recipients under this section are an alternative to payments directly to providers and are subject to the same conditions; for example, the State's reasonable charge schedules are applicable.

(2) Direct payments must be supported by providers' bills for services.

III. STATE STATUTES

New York Social Services Law § 366. Eligibility

1. Medical assistance shall be given under this title to a person who requires such assistance and who

(a) either (1) is receiving or is eligible for home relief or aid to dependent children; ...

* * *

(5) although not receiving nor in need of public assistance or care for his maintenance under other provisions of this chapter, has not, according to the criteria and standards established by this article or by action of the department, sufficient income and resources, including available support from responsible relatives, to meet all the costs of medical care and services available under this title, and is either (i) under the age of twenty-one years or over the age of sixty-four years or (ii) a spouse of a cash public assistance recipient living with him and essential or necessary to his welfare and whose needs are taken into account in determining the amount of his cash payment or (iii) for reasons other than income or resources, is eligible for aid to dependent children or federal supplemental security income benefits and/or additional state payments....

* * *

New York Social Services Law § 367-a. Payments; insurance

1. Any inconsistent provision of this chapter or other law notwithstanding, no assignment of the claim of

any supplier of medical assistance shall be valid and enforceable as against any social services district or the department, and any payment with respect to any medical assistance shall be made to the person, institution, state department or agency or municipality supplying such medical assistance at rates established by the appropriate social services district and contained in its approved local medical plan, except as otherwise permitted or required by applicable federal and state provisions, including the regulations of the department; ...

* * *

IV. STATE REGULATIONS

Title 18 New York Codes, Rules and Regulations (18 N.Y.C.R.R.)§ 352.31 Estimate of need and application of income.

* * *

(f) *Correction of underpayments to current recipients.* Local social services districts shall correct any underpayments to current recipients, and to those who would be current recipients if the error causing the underpayment had not occurred, by making appropriate payments in each case within 30 days after discovery of the underpayments. Such retroactive payments shall not be considered as income or as a resource in the month paid nor in the next following month. Judicial determinations which enjoin or declare invalid departmental policy do not create an underpayment.

18 N.Y.C.R.R. § 360.16 Authorization of Medical Assistance.

* * *

(c) An initial authorization shall be issued and made effective for inpatient and outpatient care and services provided a person during the three-month period preceding the month of application for medical assistance, if the applicant was eligible in the month in which such care or services were provided; but in no event shall an authorization be issued with respect to care or services provided prior thereto.

18 N.Y.C.R.R. § 360.17 Method of paying for medical care. (a) Any payment with respect to any item of medical care under medical assistance shall be made to the person or institution supplying the care, except that payment for services or care rendered by physicians, dentists, or other practitioners may be made:

* * *

(4) to the recipient, or his/her representative who directly made payment on behalf of the applicant or recipient, when an erroneous determination of eligibility by the agency is reversed. This includes circumstances where there is an erroneous agency decision which results in an applicant or recipient paying for medical services which should have been paid under medical assistance. Direct reimbursement is available regardless of whether the decision to reverse is the result of the agency discovering its own error, a fair hearing decision and/or a court order. Direct reimbursement of medical bills shall be limited to the rate or fee provided by Medicaid at the time the service was rendered.

* * *